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ABSTRACT

Noting that large numbers of Canadian children enter kindergarten lacking basic adaptive, social, and academic skills and that research supports the effectiveness of early intervention, this master's project proposes a model addressing effective implementation of a collaborative multi-agency early intervention program in Manitoba that is family-focused and designed to enhance success in school by focusing on adaptive, social, and academic areas. The project's literature review identifies major risk conditions, characteristics of effective early intervention programs, and the efficacy of early intervention. The proposed model focuses on child and family needs, establishing coordinated interagency/parent collaboration by means of an integrated school-linked services planning team. In addition, the model requires: (1) identification of services currently provided; (2) identification of the needs of children, families, and individual service providers; (3) identification of roadblocks to effective intervention; (4) development of innovative strategies to address roadblocks; and (5) development of strategies for evaluating the process, students, and the model. The model provides three "hubs" of service delivery to at-risk family and child: community-based facilities, school-based facilities, and the home. Steps for implementing the model are discussed, from developing the collaborative team to identifying a control group and collecting baseline data for evaluation. Anticipated results are also presented. (Contains 54 references.) (KB)

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Windows of Opportunity for At-Risk Children Through Preschool Early Intervention

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The undersigned certify that they have read, and recommend to the Senate for acceptance, a **MASTER'S PROJECT** entitled:

Windows of Opportunity For At-Risk Children Through Preschool Intervention

Submitted by Ida Filak

In partial fulfillment for the requirements for the degree of

MASTER OF EDUCATION

Date May 2, 2001

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Abstract

Children are entering Kindergarten with an appalling lack of basic adaptive, social and academic skills that place them at a definite disadvantage the very moment they begin school. This situation must be addressed. The concept of early intervention is not new. Educators have been aware of the benefits of early diagnosis and programming for a very long time. Current popular research supports the concept that learning begins literally in the womb, with the development of the auditory system. There appear to be specific "windows of opportunity" in the early years, during which the stimulated mind develops at an optimum rate. Despite this, many jurisdictions, including Manitoba Education and Training, prescribe and fund service delivery only to students of age five and older. Governments have attempted to provide inter-departmental initiatives to address the issue of early intervention with programs like such as Manitoba's Healthy Child Initiative. However, programs like the Healthy Child Initiative, while very positive in intent and purpose, are neither efficiently integrated nor do they address the specific needs of these children. This project proposes a model intended to deal with effective implementation of a collaborative multi-agency early intervention program that is family-focused and designed to enhance success in school by focussing on the three domains: adaptive, and social and academic.

Chapter 1

INTRODUCTION

Schools have experienced substantial increases in the number of at-risk children entering the educational system over the past decade. As an educator, the author was appalled and concerned at the lack of basic skills of many children entering Kindergarten. Problems commonly encountered include children being unable to appropriately interact will peers or adults, follow simple instructions, dress themselves, properly toilet themselves, and having no literacy or numeracy skills. The life experiences of these children are severely limited by factors including low socio-economic status, poor parenting, neglect and abuse, leaving them at a marked disadvantage from their classmates who come from more enriched home environments. At-risk children are in a catch-up situation from the beginning.

The educational systems in Canada have recently come under close scrutiny. Children have been subjected to standards testing and schools have been held accountable to ensure their students meet these standards. The at-risk population represents an enormous expenditure of teacher time and resources. To complicate matters, school failure is usually accompanied by other antisocial behaviors such as crime and violence that place further economic strain on society. The problems facing our at-risk children are complex and numerous but they must be addressed.

The concept of early intervention is not new. Early intervention refers to programs designed to ameliorate adverse conditions affecting children as early in life as possible. The literature overwhelmingly supports early intervention as a means of reducing risk factors and increasing a child's chances of success (Bruder, 1993; Schroeder, 1993; Ramey & Ramey,1994; Bracey, 1996; Ford & Supton, 1996 ; Reynolds, Mann, Meidel & Smokowski, 1997) . However research and educational practice differ. Despite the research that indicates the development of future capacity to learn is most crucial during the first years of life, standard educational practice dictates that formal

education starts only after age 5 or 6. Research provides ample data indicating that with intense early intervention, some adverse effects can be reversed or prevented for much less cost than needed to provide special services later. The education system waits for students to fall behind and then places them into high cost special education programs (Education Commission of the States, 1997).

In attempts to address this situation, the Manitoba Children and Youth Secretariat's CHILDRENFIRST Plan was jointly developed with collaboration from the various service providers including Health, Child and Family Services, Justice, Culture, Heritage and Citizenship, Northern and Native Affairs and Education and Training. The goals of the program, as stated in the Manitoba Child and Youth: Status Report (1999), focus on the early years and are consistent with the definition for early intervention. The Manitoba Child and Youth: Status Report (1999) also states that the program will (a) focus on the early years through stimulating, nurturing and safe environments, provide significant long term benefits to the child and ultimately the community, (b) recognize that making any changes in a child's life becomes more complex as the child gets older. This report also lists numerous programs and initiatives that are currently in place attempting to address the issues of children at risk. The list includes the BabyFirst Program, which attempts to address the needs of families and children (conception to age 3) through home visits, promoting positive parenting, and promoting healthy child growth and development. The program is to be delivered by individual Regional Health Authorities. Another is the Early Start Initiative which attempts to address the needs of preschool children ages 2 to 5 years. The stated goal of the program is to increase school preparedness focussed on literacy and numeracy. However, at-risk children are not coming to school prepared.

Manitoba is not the only jurisdiction with a renewed interest in early childhood development. Ontario commissioned a recent and thorough study of the early years programs and services in that province: Early Years Study: Reversing the Real Brain

Drain. A major conclusion of this study is that the government invests a considerable amount of money on numerous existing programs, but there is no coherent system that can meet the diverse needs of these children and their families. This conclusion begs two questions. Why not? What do we do now?

What is Early Intervention?

Reynolds, Mann, Meidel and Smokowski (1997) characterizes a well developed early intervention program as one having:

...a developmentally appropriate curriculum based on child-related activities, teaching teams that are knowledgeable in early childhood development and have received ongoing training and supervision, class size less than twenty 3 to 5 year olds with at least two teachers, administrative leadership that includes support for the program, systematic efforts to involve parents as partners in their child's education, as well as a sensitivity to the non-educational needs of the child and family, and evaluation procedures that are developmentally appropriate. (p. 3)

Reynolds' definition refers to curriculum, child-based activities and teacher and administrative support. The key to effective intervention is providing family support for non-educational needs and providing children with developmentally appropriate and specific skill focussed stimuli at the earliest possible age. It is the latter that presents the biggest obstacle in meeting the needs of the at-risk child. The solution to overcoming that obstacle lies beyond schools alone. It requires true collaboration.

Why a New Model?

Initial interest in this project stemmed from the author's sense of frustration with the multi-agency service delivery infrastructure that was in place during the middle to late 1980's. The system was characterized by a lack of cooperation. Agencies did not share knowledge, resources or skills openly. Individual "turf" was protected and information was closely guarded rather than shared with schools and other agencies. Each agency individually identified and prescribed interventions for the needs of children. As a

result, many children suffered because their specific needs were not considered appropriate for intervention because they fell outside the jurisdiction of a particular agency (Falk, 1998).

Cooperation was limited between agencies but it did take place on a personal level. Information sharing took place covertly between professionals based on personal trust relationships. This was far more effective and beneficial to children at-risk than no sharing of information, but was far from optimal.

Though recent renewed government interest in child development has resulted in the proclamation of numerous lofty ideals and produced a number of new initiatives, in reality the situation has not improved. What is required is not simply to divide up responsibilities between agencies but to re-define the roles and relationships between the service delivery partners and the community itself. The new emphasis must be shifted from focusing on the "agency" to focusing on the child and family (Falk, 1998).

This shift in approach to service delivery also requires a shift in the approach to intervention. The Ontario study (Mustard & McCain, 1999) found that there was no coherent system meeting the diverse needs of these children and their families. This is not surprising when viewed from the perspective of special education where individualization is the norm.

Moving toward a family centered approach requires that attention be paid to the naturalistic environment of the home. Individual children's developmental, behavioral, and learning problems are tied directly to a number of significant ecological factors (Barnett, 1999). Research increasingly supports the approach that child behavior changes in context (McConnell, 2000). The context is by definition the child's natural environment. The risk factors that place the child "at-risk" occur in this environment and the interventions that will ameliorate them must also be applied in the same environment to produce effective change.

Project Summary

The following examines the early intervention literature identifying the major risk conditions that need to be overcome; what constitutes an effective early intervention program; and the efficacy of early intervention programs. The proposed model attempts to focus on the needs of the child and family by establishing coordinated inter-agency/parent collaboration by developing an integrated school linked services planning team. With the partners identified, the specific roles and responsibilities must be jointly defined. The specific needs of the children and families within the school and community must be identified. The parents must then be included as full members of the collaborative team to develop a plan. Existing services and resources must be examined in relationship to the identified needs and innovative interventions must be developed to address needs where resources and services do not currently exist. Potential roadblocks to the implementation of effective early intervention must be identified and addressed.

The focus of the project is to enhance school success for at-risk children by providing intervention to develop higher level adaptive, social and academic skills before school entry.

Chapter 2

LITERATURE REVIEW

The following will review the literature and establish the study. The effect of early childhood intervention has been widely studied and documented since the mid-1960's. The majority of research supports the opinion that early intervention programs benefit children at risk (Ramey & Ramey,1994; Bracey, 1996; Schroeder, 1993; Ford & Supton, 1996, Dinnebeil & Hale, 1999; Bruder, 1993; Reynolds, Mann, Meidel & Smokowski, 1997). What is less than conclusive in the research is what constitutes "early intervention" and how the benefits can be accurately measured.

Early Intervention and the Disadvantaged:

Early intervention programs have been traditionally designed to serve disadvantaged children from socio-economically-deprived families (Ramey & Ramey, 1994). Financial poverty is a major factor.

Reynolds, Mann, Meidel and Smokowski (1997) examined a wide variety of early intervention programs to assess their effectiveness. The results indicate that well developed programs have meaningful and significant short-term effects on cognitive ability, early school achievement and social adjustment (Reynolds, Mann, Meidel and Smokowski, 1997).

Poverty:

Reynolds et al. examined four basic assumptions of early childhood intervention. The first two basic assumptions are (a) that poverty is a major environmental factor adversely affecting the healthy development in children and (b) that education and social enrichment can compensate for disadvantages brought about by poverty and its

associated ills.

Child poverty is supposedly a national issue in Canada since a unanimous House of Commons 1989 resolution to seek to achieve the goal eliminating poverty among Canadian children by the year 2000 (National Report Card on Child Poverty, 1999). The record over the past decade indicates that this goal has not been achieved. Campaign 2000 is a coalition of 70 different partnerships from federal government, provincial government, social agencies and educational institutions that are collectively attempting to tackle the problem. Their findings, based on Statistics Canada data from 1989 to 1997, show that in the last 10 years the number of poor children has increased 49%; children in families with incomes less that $20,000 increased 48%; children in families experiencing long term unemployment increased 16%; children in working poor families increased 44%; children in families receiving assistance increased 51%; children in poor 2-parent families increased 45%; and children in lone-parent families increased 61%.

The United Nations Human Development Index (1999) rated Canada as the number one country in the world in which to live. However, the United Nations Human Poverty Index (1999) rated Canada as ninth in its treatment of the poor.

The Report of the Pan-Canadian Education Indicators program (Statistics Canada 1999), released in February 2000, indicates that in 1996 1.4 million children were living in "low income families" representing a national rate of 22%. In examining individual jurisdictions it was found that Manitoba has the highest rate of child poverty in Canada at 28%. Similar results in the United States show substantial increases in the number and percentage of poor young people (NCCP Fact Sheet, July 1999).

Since the majority of at-risk children are found in this increasing financially

disadvantaged population, effectively designed early intervention programs that can help overcome the adverse effects of poverty, must be developed. David Ross (1998), Executive Director of the Canadian Council on Social Development (CCSD), presented data that shows significantly adverse effects of poverty on school success. Children from poor environments show significantly lower math scores, delayed vocabulary development, above average hyperactivity and lower functional health. In addition to these disadvantages, there are other debilitating factors to consider.

Other Factors:

Poverty has a devastating effect on family relationships. Since research, (Plant, 1999), demonstrates that the home environment is responsible for roughly half of a student's school achievement, effective early intervention must be focused on the family; both parent(s) and child. Therefore while looking at poverty as major problem, the effects of poverty must also be considered.

Research indicates several other factors that significantly affect the potential success or failure of children that may be consequences of, or exacerbated by poverty. These factors include maternal educational level (Ramey & Ramey, 1994; U.S. Education Statistics, 1996), levels of parenting skills (Dinnebeil, 1999; Mahoney & Kaiser, 1999), and parental involvement in the design and delivery of programs (Dinnebeil, 1999; Mahoney & Kaiser, 1999; McCollum, 1999).

Parent Education Levels:

A significant factor appears to be low levels of parental education. Ramey & Ramey (1994), found parental education levels to be significant predictors of a child being at-risk. Low maternal IQ was found to be the greatest factor effecting at-risk

children. The U.S. Department of Education National Center for Education Statistics cites very significant data regarding parent's, particularly mother's, educational levels on the success rates of children in school.

Based on the 1996 National Household Education Survey, the percentage of children, aged 3 years to 5 years, enrolled in a center-based preschool program was only 37% for mothers with less than high school to 73% of children of college graduates. Similarly the effects appear to continue in later years. The percentage of grade two students that are retained is 12% (down from 21% in1991) for mothers with less than high school as compared with 5% for children of college graduates. Absentee rates for grade eight to twelve ranged between 31%and 36% for students with parents with less than high school, as opposed to 18% to 25% for students whose parents are college graduates. Parental educational levels are important and to be considered in developing a high quality program.

There is overwhelming evidence suggesting that parenting/parental involvement is a key factor for providing effective intervention for at-risk children (Thomas, 1998; Dinnebeil, 1998; Mahoney & Kaiser, 1999; Walker and Kavanaugh, 1998, McCain & Mustard, 1999).

Children who lack basic skills, very likely have parents who lack the basic child-rearing skills. Dinnebeil (1999) states that optimal parent-child relationships are responsive and reciprocal. This does not characterize the typical at-risk home environment. Mahoney and Kaiser (1999), argue that parent involvement is critical to early intervention effectiveness and that parents want, and need, specific strategies to help their children's development. This supports the need for parent education.

Parent education refers to systematic activities implemented by professionals to assist parents in accomplishing specific goals and outcomes with their children. The goals of such "education" are parental assistance in attainment of children's developmental skills, parent management of children's behavior, implementing consistent daily routines, and enhancing parent skills in engaging their children in play and appropriate social interaction (Mahoney & Kaiser, 1999).

Interestingly, although parent education seems pivotal to appropriate early intervention, it appears to have been de-emphasized over the past fifteen years(Mahoney & Kaiser, 1999; McCollum, 1999). Involving at-risk parents must be included in any early intervention program.

Parental Involvement:

Simply attempting to educate parents is not enough. Thomas (1998), states that educators have long since recognized the need to work with families. In the U.S., educators have a legal obligation under law PL 99-457 to provide parents with support and information so family members can be *fully participating team members.* Parent involvement is critical to student success. Increasing family involvement is a widely accepted way to improve student performance (Fowler and Corley, 1996; Dodd, 1996). Daniels (1996) found that some effective inclusion and partnering with parents produced very impressive and progressive innovations within a number of Chicago schools. However, parental involvement continues to be low in many schools.

Daniels (1996) questions if the gap is because "parental involvement is just a ceremonial platitude", despite government mandates to the contrary. Thomas (1998), suggests that parent/school partnerships be built on mutual trust and respect with

mutually agreed upon goals, clear communication and shared planning and decision making. Dinnebeil & Hale (1999), examined parents' and service coordinators' perceptions of effective collaboration. Their findings suggest that collaboration takes place when both parent and professionals are skilled communicators who are sensitive to and respectful of each others needs. In the at-risk population these skills are often lacking.

In the Manitoba New Directions Educational Reform, community and parental involvement is one of the six foundations of education. Despite the affirmation of its importance by government, communities, and teachers, many roadblocks to parental involvement still exist. Cultural differences, social status, economic background, educational background and resources available are factors that can effect how parents interact with schools. However the essential problems may be more basic. Many teachers and administrators are leery of parental involvement (Daniels, 1996). Contact with parents often arises only when crisis and conflict occur. As a result, many parents view schools as aloof and indifferent (Aronson, 1996). Another major problem is that many of the parents involved have had bad school experiences themselves and are suspicious of the educational system. However, appropriate early intervention can address many of these issues and impact positively on a child's ability to succeed in school.

Early Intervention and Success in School:

Reynolds'(1997) third and fourth assumptions are that early intervention will increase the likelihood of later school success and that long-term effects can be achieved by extending intervention into the primary grades. Reynolds et al. (1997), reviewed a meta-analysis of 300 studies of model and large-scale projects, found that students in 36

early intervention programs later experienced significant success. These results included a 31% reduction in grade retention, a 50% reduction in special education placements, and a 32% reduction in high school drop out.

However, extending intervention into the primary grades is a very complex process. Students must make the adjustment to regular school classes, deal with new teachers and support people, and in the case of the at-risk child, still deal with the multiple risk factors occurring in their lives. To complicate matters, in Manitoba, governmental jurisdiction changes when a child enters school. Different agencies have different expectations and there is, in most cases, little or no communication between departments nor articulation of programming. In Manitoba, pre-school education requires coordinated effort and effective delivery of early (age 3 to age 5) intervention strategies in the pre-school years to prepare at-risk students for success in the primary grades.

Intervention Impact on School Success:

Although entering school presents a number of problems, a properly designed and implemented intervention can easily be extended into the primary years. McCain and Mustard (1999), state that although many programs exist, no one program can meet all the diverse needs of at-risk children. Diverse needs require an individual plan. An individualized plan would coordinate an early intervention infrastructure that may respond to the individual needs of the child and family. In addition to these assumptions, Reynolds et al., identifies four "myths" surrounding early intervention programs that require dispelling.

Cognitive Development vs. Social Competence:

Reynolds' et al. first myth is that the primary concern of an early intervention program is cognitive development. Although measurement of cognitive development and academic achievement has been the primary form of assessing children, developing social competence should be a primary goal of any early childhood intervention program (Guterman, 1997; Walker & Kavanaugh, 1998;). Social competence includes not only academic achievement but also self-esteem, attitude toward school, health status and motivation to achieve (Reynolds et al. 1997). In the context of this project, developing higher social/adaptive competencies is a main focus. Attending to these competencies has a broader positive social impact, not only increasing success rates at school, but also reducing the rate of juvenile delinquent behaviors.

Intervention and Reduction of Juvenile Delinquency:

Plant (1999) supports the social competency focus by citing early intervention programs as a means to reduce adolescent delinquency. In a 1997 meta-analysis of 49 different intervention programs, it was concluded that the factors contributing to later delinquency were primarily social/environmental. These factors include childhood disruptive behavior and intellectual deficits, family characteristics, parental discord, rejection of the child, ineffective discipline and poor supervision, community characteristics with high crime rates and disorganized schools; and association with anti-social peers. The findings of this study concluded that early intervention programs may have a very positive effect on the mental development of infants and toddlers (Plant, 1999). Close attention should be paid to appropriate intervention design.

Appropriate Curriculum Design:

Schweinhart and Weikart (1997) looked at three preschool intervention curricula. The curricula studied were direct instruction, the High/Scope curriculum and traditional Nursery School curriculum. Both the High/Scope curriculum and the Nursery School curriculum had social competency components, while direct instruction focussed on development of cognitive and academic skills only. In a 23 year longitudinal study they found that the participants of the child-centered curricula, High/Scope and Nursery School, found 10 significant advantages over those students who were given direct instructions as an intervention. Cognitive development and academic achievement were not listed among them. However, social interaction was deemed a crucial factor in the intervention.

Intervention and Social Interaction:

The advantages of social interaction curricula include a significantly reduced need for treatment of emotional impairment or disturbance. Emotional problems stem very often from neglect and abuse. Successful proactive intervention helps prevent the various abuses and neglect that social agencies have historically dealt with only after they occur (Guterman, 1997).

Participants of these programs demonstrated a significantly higher rate of volunteerism, demonstrated significantly lower rate of acts of misconduct, and developed more positive adult and peer interactions.

Positive social interaction results in a greater ability to work with others. Building more trusting relationships lead to a significantly higher involvement in and commitment to personal relationships as well as significantly better work records.

Participants of these programs also demonstrated significantly lower arrest rates, a zero arrest rate for poverty-related crime, and significantly lower felony arrest rates. Consequently, higher levels of social competency exhibited by participants of these studies suggest that the goals of a preschool program should not be limited to academic preparation but should include the development of positive decision making and interpersonal skills.

Early Intervention and Long Term Disadvantage:

Reynolds' et al (1997), second myth is that participation in a program inoculates a child from a high-risk environment. Although participation in a well-developed program may have a very positive effect on a child (Plant, 1999,Reynolds, 1997, Schweinhart and Weikart, 1997), Zigler and Styfco (as cited by Reynolds et al., 1997) stated, early intervention can not overpower the effects of poor living conditions, inadequate nutrition and health care, negative role models and substandard schools.

The myriad of negative factors affecting at-risk children require interventions with a family centered focus (Drummond, Kysela, Alexander, McDonald, & Query, 1997; Bailey, McWilliam, Darkes, Hebbler, Simeonsson, Spiker & Wagner, 1998; Kimber, 1998; McDonald, 1998.) Key components in family-focused interventions are parental education (Dinnebeil, 1999; Mahoney & Kaiser, 1999; McCollum, 1999.), and developing true collaboration between parents and interagency resource personnel (Bruder, 1993; Golly, Stiller & Walker, 1998.)

Appropriate Intervention:

The third myth is that early childhood programs are homogeneous. The literature indicates that the efficacy of any early intervention program depends on the specific

design of the intervention program (Dinnebeil & Hale, 1999; Bruder, 1993; Reynolds, Mann, Meidel & Smokowski, 1997); Thomas, 1998), and reliable evaluation (Barnett, 1999; Barnett & McMann 1992).

Schweinhart and Weikart (1997), examined three very different programs, looking at curricular design, structure and effectiveness. The results of this study clearly show that all interventions are not equal. Reynolds et al. (1997), found that even though the majority of interventions are funded through government agencies, there is very little or common structure. Individual program staff and parents have wide flexibility in design and structure of most programs. An interesting consequence of this particular misconception may be that policy makers and administrators may financially favor generic programs serving large numbers of children over well-designed, comprehensive programs to smaller numbers (Huston, 1995; Reynolds et al. 1997). At-risk students are as diverse as any other segment of the population. Therefore, the approach to addressing these diversities lies in the family focussed grass roots intervention suggested in this proposed model.

Diversity of At-Risk Students:

The fourth and final myth is that the population of at-risk children is homogeneous. "At-risk" is not easily defined and may include a myriad of adverse criteria. The common criteria that have been examined include low family income, low levels of neighborhood poverty, neglect, sexual abuse, psychological abuse, parental discord, anti-social peer relationships and physical abuse (Guterman, 1997, Plant, 1999, Reynolds et al. 1997). Statistics Canada, (1999) indicate that these children have higher rates of emotional and behavioral disorders and therefore are less likely to perform well in school. Addressing these debilitating factors requires a common definition of what constitutes "at-risk" and the coordinated support of the educational system, social

services and parents. This requires the financial and political support of government.

Governmental Involvement:

As discussed earlier, governments have been under pressure to address the issues of at-risk children for some time. Governmental support at the federal level, for early intervention programs in the United States has been in place since the implementation of the Head Start program in 1965. The major goal of the program was to enhance social competence, improve school readiness, health and nutrition, and social psychological development of primarily financially disadvantaged children.

In Canada, education has always been a provincial jurisdiction. In recent years the educational system has been a primary target of budget cutting as provincial governments have struggled to reduce deficits. However, it has become apparent that the adverse effects of cuts to education are being felt. Several factors, including the increasing numbers of children in poverty, lower scores for Canadian children on international standardized tests, and a perceived lack of global competitiveness (McCain and Mustard, 1999) have resulted in a review of education in Canada. This review focussed on young children and the factors impacting on early life experience that have a significant effect on how well a child will succeed in school. On a national level, the Federal-Provincial-Territorial Council on Social Policy Renewal initiated Stakeholder Roundtable Discussions in June of 1999 to determine a National Children's Agenda. The result was the identification of six major themes.

The first theme is the need to support parents and strengthen families. Stakeholders recognize the importance of the role of parents and how deterioration of the nuclear family, increasing poverty levels and social stresses affect families. Governments at all levels need to provide supports to families at-risk. The second theme centers on enhancing early childhood development. Recent popular interest in so-called "Brain Research", has prompted provincial governments, Manitoba and Ontario included, to re-examine the efficacy of their social policy and programs as they pertain to young

children. The third theme centers on improving economic security for families. The stakeholders recognized that not only sustainable employment is necessary, but so is adequately paid employment. Addressing increasing poverty levels and the needs of the working poor, should be a primary focus of all levels of government. The fourth theme identified was provision of early and continuous learning experiences. This particular area requires providing far more support than is presently available and making it accessible to many people who have no access at the present time. Services in rural and northern communities are minimal to non-existent. The fifth theme addresses fostering strong adolescent development. The majority of adolescent programs tend to be reactive rather than proactive (Guterman,1997). Services and resources to adolescents like those for early years are minimal. The sixth and final theme is the creation of supportive, safe and violence free communities. The forum concluded that this was a shared responsibility between all levels of government, communities, and students and schools, with an educational component.

McCain and Mustard (1999), published the Early Years Study for the Province of Ontario. The study examines a number of factors effecting young children. The primary issue in the discussion of early intervention is the review of the mismatch of opportunity and provincial investment in early-years development. Authors of the report, McCain and Mustard, found that Ontario spends two and a half times more on children after they enter school than before they enter school. There are a considerable number of provincial interventions in place. However these are basically a "patchwork" of treatment programs reacting to specific problems rather than an integrated system to deal with prevention and early development. Since all families would benefit accessibility should be available to all families at all socioeconomic levels and that is not the existing case.

The report acknowledges that investment in early childhood development will be much more cost effective than remediation later in life. Acknowledgment that other jurisdictions, globally, have also recognized the importance of early childhood

development, has prompted other governments to assess their existing systems. In Manitoba, the Children and Youth Secretariat was created to address the same issues. The result of the Secretariat's work is the Manitoba CHILDRENFIRST Plan. The Children and Youth Secretariat's Status Report, issued in May 1999, describes the "new" approach as being based on three principles. The first is prevention/early intervention, focusing on all the important early years of a child's life. The second principle is supporting and strengthening families and communities, particularly aboriginal communities. Further, the third principle is the reduction of barriers, whether cultural, social, or financial, by providing coordinated, accessible, outcome-based services.

A closer examination of the Manitoba document reveals that, despite the admirable principles that are consistent with the National Children's Agenda and other provincial bodies, the situation is very similar to that of Ontario. There are indeed prevention/early intervention programs in place. However, they do not appear to be effectively coordinated. Whether in Manitoba or Ontario, programs are not universally available to all socioeconomic levels or geographical locations.

The Baby First Program is carried out under the mandate of Manitoba Health. This program works with mothers of newborn children to age 3 years. Early Start is a program that provides a trained home visitor to help improve parenting skills, health and family well being. This program is a joint effort of the Department of Health and Child and Family Services. The Daycare Directorate provides the Child First Program. This program deals with children, receiving daycare, ages 2 to 4 years. Each of these programs supposedly strives to meet the goals of effective early years development. However the key to success and failure lies in the availability and delivery of community support services (Armbruster, Andrews, Couvenhoven & Blau, 1999; Ambruster, Gerstein, & Fallon,1997; Armbruster a& Lichtmann, 1999). This is particularly significant in rural communities where these services are limited or nonexistent.

A further problem lies in the fact that the above-mentioned programs are

voluntary. Parents may or may not choose to participate or may not be able to afford to participate. A major roadblock to overcome is that many of the parents that have the highest need for inter-agency services have had negative experiences with outside agencies like Manitoba Health and Child and Family Services. Similarly, these parents very often have had bad school experiences themselves and are suspicious of the educational system.

Though several inter-departmental protocols exist, in reality there is no integration between departments. The various departments within the government services are independently staffed and funded, with each having a specific mandate. Communication between and within some departments is minimal. Describing a situation that illustrates this, a regional health nurse was supplied with an inter-sectoral policy and procedural document, by a school student services coordinator. The document had been written by Manitoba Health. Public health personnel were unaware of the document even though schools had been operating under the document guidelines for 18 months.

Manitoba, like Ontario, appears to have a "patchwork quilt"(McCain & Mustard, 1999) rather that the integrated system of services that may or may not be accessible to all families and communities. A major outcome of this project is to coordinate the services of agencies involved with young children. Another major outcome will be to address a number of specific "risk" factors.

Risk Factors

Teachers and administrators are well aware that there are increasing numbers of at- risk students entering the school system with very limited life experience. This may be directly connected to the socioeconomic environment and the resulting increases in numbers of children living in poverty (McCain and Mustard, 1999, Campaign 2000, 1999). Many of the students entering school have little to no basic knowledge or skills. Many have no experience with books; don't know the front of the book from the back;

don't know that one reads from left to right. Many can't count, recognize letters or numbers, or identify colors.

In the social domain, many have no social skills, are unaware of rules, have no concept of cooperation and have no concept of how to behave within the school's social context. In the adaptive domain, many can't tie their own shoes or recite their address or phone number. Many also come with anti-social behaviors (Guterman, 1997), learned in homes characterized by physical and/or sexual abuse, depression, substance abuse and aversive family interaction. These children are at a marked disadvantage from their 5-year-old classmates who come from an enriched experience base.

These students can achieve the learning outcomes of the curricula, but they have limited prior knowledge to connect to new information. In many cases, these students are two to three years behind their fellow kindergarten students. Many repeat primary grades. This has a detrimental effect on, what in most cases, is already very low self-esteem. The gap in skill levels tends to persist in many children through to middle school. Risk of drop out is very high (Plant, 1999).

Addressing the three "risk" factors: lack of positive early life experience, poor social interaction/social skills, and low self-esteem is critical to the planned intervention. To do so requires not only focusing on the deficits of individual children and their parents, but also on the strengths that exist in the entire family unit despite any adverse conditions.

The child exists with a framework of three systems: home, school and community. Several factors have been identified as assets within the family that contribute to resiliency in at-risk children. Three of these factors (Howard and Dryden, 1999) are of particular interest to this project.

The first is the availability within a household of caregivers, apart from the mother, all of whom are prepared to provide substantial amounts of attention to the child in infancy. Extended family, aunts uncles, cousins, can play an important role in

providing positive experience to the child.

The second factor relates to family cohesion. Families, even in very adverse conditions and suffering internal strife, may show a very strong family presence to the community. Accentuating family pride is a positive factor in building self-esteem.

The third factor is that many at-risk families have an informal multigenerational network of kin. This extends considerably beyond direct blood relatives to include in-law, blended family, stepsiblings, and their families as well. Each relationship presents a possible resource through which additional service can be provided. The key is to develop a trust relationship with not only the direct family, but with all levels of the kinship group.

Where these "assets" exist they should not be ignored. The cultural make up of the community is essential to developing an effective program of early intervention. By focusing on developing resilience in very young children, rather than focussing simply on the deficits present in the home, we can expand the intervention to include the extended family.

The question is how do we effectively address these risk factors when existing, well-intentioned programs appear to be ineffective? What collaborative model will be effective?

Interdisciplinary Frameworks for Collaboration

Morgan (1995) reviewed three interdisciplinary collaborative frameworks. The first framework is the interdisciplinary or multi-disciplinary model. This approach brings together a group of specialists to give their separate and "expert" perspectives on the issues. This model has been in existence since the 1950's and has experienced limited success due to "overly narrow professional disciplines created by higher education, and credentialing systems" that inhibit an holistic service delivery (Morgan, 1995).

The second framework is the cross-disciplinary approach in which specialists from closely aligned disciplines work in positions usually assumed by professionals from

another discipline. For example, a social worker might work in an early childhood education/daycare setting. The benefit of this approach is that the professionals have an opportunity to experience situations from a slightly different perspective.

Each of these approaches, Morgan (1995) contends, is built on the strengths of the traditional disciplines. The third approach, the trans-disciplinary model assumes that the traditional disciplinary assumptions are limiting factors in achieving specified tasks. The trans-disciplinary model advocates team members developing new and creative ways to address issues rather than relying on their traditional discipline-specific frameworks.

When considering which framework would best apply to this project, policy, both intra-discipline and extra-discipline must be examined.

Policy Perspectives vs. Program Perspectives

Two separate perspectives of service integration exist (Morgan, 1995): the policy perspective and the programmatic perspective. Morgan (1995) cites a definition that " Policy is an official agreement between people that will act in predictable ways because to do so in the public interest. Program, on the other hand, is a specific action targeted to a specific group designed to solve a specific problem."

Each perspective has a different focus. The policy perspective focuses on utilization of existing community services, reduction of duplication, and accountability for funding. The policy perspective calls for delivery of services to all children while the program perspective focuses on providing comprehensive service to a specifically targeted group by concentrating the services in one place. The programmatic perspective calls for development and implementation of interventions and services to sprcific individuals or small groups.

The two perspectives would appear to be contradictory. Indeed, some (Esterline, as cited by Morgan, 1995) would argue that the program perspective creates gaps and overlaps, fragmentation of services and turf guarding. On the other hand small, autonomous programs are extremely successful (Morgan, 1995). Morgan (1995) and

Hardin & Littlejohn (1994), caution that from a service perspective, bigger is not necessarily better; bureaucratic systems are not automatically better than smaller, more specific service delivery systems. Examples of successful models exist for both perspectives. What makes an effective model?

Elements of an Effective Program Model

As discussed earlier in the chapter, research indicates that improved communication and involvement of the family are instrumental in providing effective interventions. Hardin & Littlejohn, (1994), examined several collaborative model designs using both an administrative approach (top-down), and a grassroots approach (bottom-up). Regardless of the design approach used, they found that several elements that were common to all successful models.

The first element of success was that all of the collaboration team members were fully committed to making a change. The second element was the acknowledgement and acceptance of the parent role in the collaborative process. High levels of trust and open communication between parents and collaborative team members, was the third important element. The fourth and final element, closely related to the third, is the types of information shared between the families and the teams. Traditionally only the "bad" events were shared with parents and team members. Successful models provide a more nurturing relationship were the child's successes as well as the failures are topics of discussion.

Summary

In summary, the literature affirms that early intervention works. Appropriately designed intervention can ameliorate the effects of poverty and associated ills. It can increase school performance and those effects can be long term. The research also emphasizes the importance of developing higher levels of social competence. This is a key consideration of this model. The initial concern of the author was the lack of basic adaptive and social skills demonstrated by children

entering school that hinder academic success. Developing social competence, that is higher level social and adaptive skills, is as integral to the project as is developing literacy and numeracy skills.

Several other considerations are important in developing an appropriate early intervention plan. Parents must be genuinely included. They may require support and training but must be actively engaged in the entire intervention process. In addition to parents extended family should be included in the process.

The school system is only one component in what has to be a multi-agency team. The support necessary to address the myriad of issue facing at-risk children and families requires a coordinated approach, which despite many well-intentioned existing programs, is lacking in many jurisdictions.

Finally, a well designed intervention creates a supportive infrastructure that may address the needs of individual children and their families, rather than addressing any single social need.

Chapter 3

THE MODEL

Following is the model that the author proposes to facilitate early intervention. There are three key points to be considered: (a) to genuinely involve the parents and extended family in the intervention process, (b) provide a coordinated multi-agency trans-disciplinary approach to intervention, and (c) to individualize the program to meet the needs of both child and family.

Outline of the Model:

The model is essentially home-school-community based, and is different than the community based model and the school based models of service delivery.

Community-based models are seen as hubs of family support service. The major premise being that families and children will be most comfortable seeking services in the natural setting of the community (Morgan, 1995). School-based models attempt to create a hub by co-locating services in one place that is both familiar and convenient for the client families. Both models have advantages. However, the community-based model requires the voluntary participation of the families involved. Many at-risk families are reluctant to become actively involved in voluntary programs on their own initiative. The school based model targets families with children already in the school system. This model reaches children after the optimal age.

This model proposes using the strengths of both community and school based delivery systems, plus extending the intervention into the home environment as well. The model requires:

i) Development of a trans-disciplinary team of professionals at the community level.

ii) Identification of the services currently provided;

iii) Identification of needs of children, families, and individual service providers;

iv) Identification of roadblocks to effective intervention;

v) Development of innovative strategies to address roadblocks

vi) Develop strategies for evaluation the process, the students, and the model.

Addressing these points requires a different philosophical approach than that of current policy and practice.

Philosophy:

The program should strive to develop an atmosphere of unconditional acceptance of the at-risk family and child. Studies, (Health Canada, 1998; Kimber ,1997; and Drummond, 1997) indicate that many existing social programs utilize ineffective practices. Facility-based programs that were administered in unfamiliar surroundings were found to make clients uncomfortable and reluctant to participate. Furthermore, clients in these programs feel that programs tend to be conditional, in that they must perform to certain qualifying criteria to obtain assistance, leaving clients feeling stigmatized. Findings also indicate that staff members often intimidate clients. Professional staff use jargon rather than plain language and dress more formally than the client, setting them apart from the children and families with whom they are attempting to work. Attitudes identified as very important include a basic concern for the family, an honest appreciation of the parent as a team member and an emphasis on family strengths rather than ills (Dinnebeil and Hale, 1999).

Providing a coordinated multi-agency approach requires a shift from the conventional paradigm. The multidisciplinary approach to intervention, as discussed in Chapter 2, has not produced the desired changes (Mustard and McCain, 1999). What is required is the innovation and flexibility that the trans-disciplinary approach provides.

Covey (1989) stated that the collaborative team does not have to be at the mercy of the interdepartmental status quo. The team can take the initiative to accomplish the shared values and purposes of the individuals involved. The key to doing this lies in developing a strong unity of purpose for the collaboration team. It must be a partnership

based on shared responsibility, shared decision making, shared problem solving and open two-way communication (Hardin and Littlejohn, 1994).

Finally, the approach to providing any intervention must be individualized as opposed to programs that have pre-determined packages aimed at "curing" the ills of an entire community.

Location:

The program should provide community based service in a location that is familiar and where people are more likely to feel comfortable. While utilizing the existing programs that currently focus on service in a specific community location like a school building, this program will be extended to the family in the home environment, through regular home visits, as early as possible. To effectively do so requires the coordination and collaboration of a team of professionals.

Developing the Collaborative Team:

Research states that effective early intervention can only be provided in the context of a collaborative relationship between the family and the professionals working with them (Dinnebeil and Hale, 1999).

The collaborative team should include essential personnel from each of the service providers working within a community. The first team member is the public health nurse. This person has access to all children and families within the community, from birth to age 3 year in the home environment on a regular basis. The second team member is the nursery school teacher, where a nursery exists, and/or the daycare coordinator in the community. Both of these positions are essential to the project because they provide access to children, aged birth to 4 years, who are too young to be in the school system.

Within the school system, key people include the Kindergarten teacher, the resource teacher, and the school principal. The principal has a key role to play as project coordinator. The principal generally will have contact with other agency on a regular

basis and is in a position to facilitate communication and planning within the group.

Child and Family Services and Mental Health should provide two additional team members that are essential to providing information, designing and implementing intervention for identified high needs children and families.

Involving these team members will provide access to a larger database of information and a broader perspective on the needs of at-risk children and their families. While individual agencies are mandated to work with families and children of specific ages or personal situations, this team should be able to work with children of all ages.

Several preconditions for successful collaboration have been identified (Morgan, 1995). The team must share their knowledge of the different systems (agency policies etc.). Each member must share perceptions of the shortage of various resources and how it will impact on service delivery. Members must have the autonomy to act within the team. Since no additional funding is available for the project, each member must be responsive to their own funding sources to ensure optimal use of the dollars available. Lastly, it will be essential that each member of the collaborative team have a shared vision and demonstrate a deep personal commitment to the project and its goals.

Research has shown that collaborative teams benefit from inservice training (Whitten & Dieker, 1995). If possible the staff should include people with similar cultural/ethnic background and understanding. All staff would benefit from cross-cultural training.

Effective early intervention lies in open and clear communication (Bailey, et al, 1998). The team members must have or attain appropriate communication skills, such as active listening, consensus building, observational skills, reading body language, and sensitivity to cross-cultural factors previously mentioned.

Whitten and Deiker (1995) stated that in addition to effective communication, collaborative teams felt that training on how to function as a team was the greatest need. Hinojosa, Bedell, Bucholtz, Charles, Shigaki, & Bicchieri (2001) emphasize that the key

to effective collaborative team development is the ability to take the time to reflect on the process. Team building will be an integral part of the project from the outset. The collaborative team should be a cohesive unit.

Delivery:

There are several key considerations for the service delivery system. Including the community in the planning process is essential. While most planning for early interventions are done for or "to" the community, this model encourages inclusion of the family, extended family and community members from the outset. Inclusion of the community allows for a wider perspective on the ethnic and demographic needs specific to that community. Essentially, the people become the focus rather than the institution (School, Health, CFS, etc.).

Flexibility and diversity are essential. Each at-risk child and the family will have individual needs; each intervention will have to be individualized to some extent. Intervention must be family centered with full and meaningful family involvement. As well, intervention must be built on the strengths and competencies of the family unit. Recognizing family strengths and acknowledging family contributions will allow for growth and increased independence as the program proceeds. Accomplishing this will depend on building a trust relationship with the family.

The team, should initially share information regarding potential at-risk families, inventory the resources available, and examine any existing relationship between various agencies/team members and the family and child. Strategies should be developed to create or enhance the relationship between the team and the family. The team must be careful not to overwhelm or intimidate the parents or family.

The last and most important consideration in this delivery model is that services from all providers should be coordinated. The pooling of resources is an absolute necessity in the face of decreasing funding to all levels of government services. The various service providers should come together, clearly delineate their respective role in

addressing the needs of their clientele, identify the resources available, and jointly participate in developing the interventions with the child and family.

Levels of Delivery

This model has two levels. The first is ongoing and delivered to all children regardless of at-risk status. The school's primary concern is to provide early intervention that will increase the at-risk child's success in school. Therefore the approach and the involvement with each of the various service providers will differ. The coordination with Manitoba Health (Baby First Program) will primarily involve communicating timely and appropriate information about child development and providing material resources to parents of infants. As a part of their regular home visits, the Health nurse will deliver the information regarding developmentally sound activities that will help their child achieve in school, and reinforce the message on all subsequent visits. The school will provide the materials for Health and work directly with the community workers to ensure that the material is clear and understandable to parents. This will be provided to all children and families and not just those considered at-risk.

At-Risk Population Identification

The at-risk population will require a more individual approach. The team members should develop a clear and common definition of what constitutes at-risk. A set of identifying criteria will be developed to assess the potential at-risk families and children. Initial criteria may include:

- socio-economic status;
- services presently in place;
- family violence;
- abuse;
- parental situation; and
- extended family;

Each team member will be included in the process of developing the initial list of at-risk

criteria and any subsequent revisions.

Given the school's current mandate to provide educational services to children from age five and older, cooperation with the daycare system is very important to the effective delivery of intervention prior to school entry. In communities where these daycare services do not currently exist, they must be developed. The school can be instrumental in setting up a facility by providing space and available resources. Most school divisions have policies in place to allow for nursery schools to be incorporated into school buildings subject to provisions that ensure the education mandate is not circumvented.

Having the nursery/daycare program in the school building will have an enormous and positive impact on the children. It will allow the kindergarten teacher, resource teacher and other team members to observe children two years prior to formally entering school. This observation will allow identification of deficiencies in basic skill areas. The team, including parents, will develop interventions to address these deficiencies.

Intervention Design Consideration

Weissberg and Greenburg, (1997), considered several components essential in an effective intervention program.

The first requires the creation of developmentally appropriate curriculum based on child-related activities. This will be done by examining the list of perceived deficiencies in basic skills currently exhibited by the at-risk children. The curriculum will be developed by the team to be delivered in the at-risk home as well as incorporated into the existing nursery school program. It will be comprised of child centered activities specifically designed to develop the adaptive, social, and literacy/numeracy skills required by the child to enter the regular school system.

Secondly, the collaborative team must be knowledgeable in early childhood development. Ongoing professional development should be provided for all members of the team. An advantage of a trans-disciplinary team is that each member has a related but

slightly different background. Each member should be a valuable resource to the other members. Research and information will be reviewed and shared by the project coordinator on an ongoing and regular basis.

Thirdly, class size should be less than twenty 3 to 5 year-olds with at least two teachers/supervisors. Day care facilities provide an excellent opportunity to involve parents in the education process. Many schools use parent volunteers or are prepared to train parent volunteers to work with children. Wherever possible the parents of at-risk children will be included in the intervention delivery process.

Administrative Support

A key element to the success of any program is the support of administration. The project must have the support of not only the principal, but the Board of Trustees as well as the Superintendent. As discussed earlier, senior administration with each service-providing agency must be on-board and supportive of the project.

Systematic efforts to involve parents as partners in their child's education is essential to program delivery. Parents will be involved in every aspect of the project through home and school visitation, involvement as volunteers, school newsletters, and training sessions. The principal is the key person within the school. The principal is the person who has the authority to ensure delivery and supervision of the program within the school building and who is normally the designated contact with outside agencies. The principal should also be the designated project coordinator.

Non-educational Concerns

Team members should maintain a high degree of sensitivity to the non-educational needs of the child and family. Some collaborative team members may live in the community and will be aware of issues facing the client families. It should be imperative that all concerns or issues of a community nature are shared with the team as a whole.

Assessment and Evaluation Procedures

Assessment practices used with children and their parents are intended to provide useful information that will (a) contribute directly to the intervention design by identifying the specific needs of the child, (b) improve evaluation, and (c) better the child and family's situation (McConnell, 2000).

Barnett and McMann (1992) suggest that assessment issues to consider must include (a) identification of individual needs, as discussed in section 3.6, (b) diagnosis and labeling of childhood disorders that may (or may not) be present and (c) placement of the child into a well designed and effective intervention program. The major advantage of this proposal is the availability of professionals on the team capable of assessing needs at all levels: social, cognitive, psychological and academic.

Eco-Behavioral Analysis

A basic premise of the project is that it should be family centered as opposed to child centered. The project therefore should conduct, by necessity, eco-behavioral research. Eco-behavioral research adopts the view that child behavioral change takes place within the child's specific setting and therefore is influenced by the variables within that child's environment. The interventions must therefore be designed to identify the negative influences in the child's natural environment(s) and replace them with positive influences that will bring about the desired changes. This approach will require all team members, including parents, to participate in data collection. The child's behavior and any changes to those behaviors must be observed in each of the child's natural surroundings: home, nursery, playground, and in the community.

Two basic principles of naturalistic intervention are (a) to apply the least amount of effort and (b) the simplest methods possible to effectively accomplish the desired change (Barnett, 1999). The problems associated with a naturalistic approach lie in the heterogeneous nature of the at-risk child and in the diverse family environments. As discussed earlier (Mustard and McCain, 1999), this diversity of needs is the reason that so

many of the existing child centered and prescriptive programs are unsuccessful in addressing the needs of the at-risk population.

Basic Accountability

Barnett (1999) states that assessing the basic accountability of any intervention requires the asking of three major questions. First, what level of efficacy was achieved? In other words, did the planned intervention produce the desired changes in behavior? Secondly, what level of acceptability was achieved? Did parents and teachers find the interventions in line with their beliefs and expectations? Thirdly, what was the level of practicality? Did parents, teachers, and home care workers find the interventions relatively easy to implement and maintain?

Evaluation procedures that are developmentally appropriate must be obtained or developed and data accurately collected and recorded. Although there are many evaluation instruments available, the team should be prepared to develop their own instruments designed to observe or measure the specific desired social, adaptive and academic behaviors that the intervention(s) target.

Summary

In summary, this model attempts to provide three "hubs" of service delivery to the at-risk family and child. The three service delivery "hubs" are (a) any existing community-based facilities, (b) any existing school-based facilities and, (c) capitalizing on the home as a third delivery "hub".

A key factor in successfully implementing the tri-hub model should be developing the collaborative team. Success or failure will depend on the commitment of the team to attain the goals of the project. Other factors to consider include developing administrative support, attending to non-educational issues affecting the family, and developing appropriate assessment and evaluation techniques that will provide the parents and the team with valuable information.

The goal of the model is to develop a truly collaborative environment that utilizes

the strengths of each of individual team member to provide art-risk children with the basic social, adaptive and academic skills they need to succeed at school.

Chapter 4

IMPLEMENTATION PLAN

Implementing the model will require following a series of steps, to ensure that each phase is fully and effectively developed.

Establishing the Collaborative Team.

The development of the collaborative team is essential to the project. Although the project has been defined from a programmatic, "grass roots" approach, it would be advisable to obtain approval in principle from the individual service providing agencies.

The primary service providers that should be involved in the project are Manitoba Health (Public and Mental Health Services), Child and Family Services, the Daycare Directorate, the Department of Education and Training, and the implementing school division board. Daycare or nursery schools may be privately run in some communities. These individuals should be included at the collaborative team level.

An initial meeting should be called with representatives at the senior administrative level from each of the partner agencies. These would likely include the school division superintendent and/or the student services coordinator, the principal(s) of the participating school(s), the regional consultant for the Department of Education and Training, the regional director of the daycare center(s), the regional health nurse and the director of the local Child and Family Services organization. The purpose of the initial meetings should be to discuss the purposes and goals of the proposed intervention, and to present and explain the model of service delivery.

Assuming senior administration would approve the plan in principle and give

permission for their personnel to participate, a second meeting should be scheduled for front line personnel. This group should include: the community health nurse, the CFS case worker(s), the daycare worker(s) and/or nursery school teacher, the kindergarten teacher(s) and school principal. This group should form the initial collaborative team.

The first meeting should review and clarify the perceived problems facing each of member individually and collectively. The goal of this meeting should be to develop a common vision. A number of subsequent meetings should be scheduled to (a) develop a common definition of what constitutes "at-risk" and a functional set of criteria to identify at-risk children and families, (b) identify the specific skills that place these children at risk of school failure, (c) define the roles of each member and the process for collaboration, (d) consider the role of the parent as a collaborative team member, (e) prepare an inventory of existing resources and materials, (f) identify the present and potential roadblocks and possible solutions, and (g) develop an initial plan with all participants. Several preconditions should be in place before these collaborative meetings take place.

Preconditions

A specific individual should be designated coordinator of the project. The school principal should be the most likely candidate, since many of the principal's functions should already overlap with this position. The principal is regularly in contact with the other agencies involved in the community, is in contact with parents for various reasons, and has the authority to provide space and resources to the community. Each of the team agencies has a number of desirable preconditions that should be in place prior to developing any specific planning.

Given the importance of access to preschool children, should the community not have a daycare/nursery school in the community as previously stated, one must be set up. The school team members, specifically the principal, should contact parents of preschool children ages 3 and 4. Parents of younger children may not be contacted, as many division policies restrict attendance of children under 3 years of age. The purpose of the initial contact should be to briefly explain the benefits of nursery school and to identify those that would be interested in having their child participate. The school should be able to provide the classroom space and fixtures. The school team is should responsible to develop informational materials, in addition to those provided by the daycare, to parents.

The nursery school director should meet with all interested parents to discuss the formation of a nursery school in each community and with sufficient support setup and license the facility. Qualified personnel should be supplied. The director and the person appointed should be prepared to work very closely with early years school staff. At this stage parents should be committed. In a nursery school/daycare situation parents should (and must) be responsible to form their own regulatory board and provide policy and volunteer assistance to the nursery staff.

Manitoba Health Services should be prepared to support the concept of the nursery school during all home visits and office contacts with parents. Child and Family Services should be prepared to offer parenting skills workshops. The school should be prepared to set up and coordinate these functions in conjunction with Manitoba Health and Child and Family Services.

Defining "At-Risk"

As discussed earlier, it is essential that the team should develop a common definition of at-risk and select the criteria to be used when identifying the children at-risk. A suggested starting point would be the common risk factors identified in the literature (Chapter 3). In addition to defining the risk factors acting on the family, the group should also identify the specific skills the child needs to be successful in school.

Identifying the Basic Skills That "At-risk" Children Lack

The primary concern of this project is that many children entering the school system have a lack of basic skills. This feeling is prevalent among many early-years teachers. In response to this perception, the author held a meeting in March of 1999 with nine Kindergarten teachers, two school principals and two community health workers to discuss the perceived problem and to develop a list of the skills that the group felt were lacking in a very high number of young children and kindergarten students. The teacher group developed the following initial list of skills that they felt many Kindergarten students lacked when they enter school, but should have as a minimum to keep up with the other students:

Adaptive Skills

- dress independently
- perform proper toileting and personal hygiene (wash hands, blow nose)
- clean up after themselves
- eat lunch independently
- tie shoes

Social Skills

- demonstrate basic manners (please and thank you)
- use appropriate and positive language
- share

- speak appropriately (no baby talk)
- demonstrate non-violent conflict resolution

Academic Skills

- print name
- demonstrate an exposure to scissors, glue, and crayons
- recite nursery rhymes
- demonstrate book knowledge(front/back/top/bottom/left - right/pictures)
- identify the alphabet (letters and sounds)
- count orally 1 - 10
- recognize colors
- recognize basic shapes (square, circle, triangle, and rectangle)
- demonstrate and share family knowledge/personal history.

Although the academic skills are important, the group felt strongly that all three areas were of equal priority. The list is by no means comprehensive but should provide a starting point for the collaborative team. It does however, indicate the gap that at-risk children face as they enter school. Schools are faced with the added responsibility of providing these students with the very basic skills that other children have acquired at home prior to arrival at school. Schools do an excellent job of teaching these skills. However the gap that is present as these children enter school is often never completely closed.

Team Members and Their Roles

The school team should be made up of the principal, the kindergarten teacher and the resource teacher. The role of the school team should be to make personal contact with all parents of children preparing to enter Kindergarten. Traditionally parents are invited to a Kindergarten orientation in the Spring of the year that their children are to start school in September. One problem is that the parents who attend are very seldom the parents of at-risk students. Reasons for not attending may vary from distrust of the

school system to both parents working several jobs. This project would require a far more aggressive approach to parent contact. In order to do so effectively, school team members should work directly with members from Health and Child and Family Services and parents of at-risk families.

Public Health personnel should have access to the home through regular home visitations. Sharing information is essential to determining the needs of the at-risk family. The time frame will be very important. Children should be identified at-risk as early as possible. The target should be to identify "at-risk" children no later than age 3 or earlier. The school's role to this point should be to develop appropriate informational materials regarding growth and development of children, specifically as it relates to school success that can be delivered to the parent by the Health nurse. This material should include a list of behaviors and skills that will greatly enhance their child's chances of success in school and specific materials and resources to help parents teach their children the required skills. In the event that Public Health Services is not available, school personnel should be prepared to do regular home visits.

The school should also provide access to classrooms and libraries for parents and their children on a regular basis. In conjunction with Health personnel the school can provide space for parent training sessions. As well the school should provide parents with access to the early years library. The school should initiate a reading/book lending programs to familiar parents with books and encourage reading with their children.

The role of the community health nurse will be to disseminate information and materials developed by the school teams. As discussed the health nurse should be the primary contact in the home. She should reinforce the importance of reading with children as early as six weeks old. As the early contact, the nurse should share any and all information that pertains to any developmental delays in children that may impact on school success. The team could then develop effective intervention.

Child and Family Services should be prepared to provide parenting skills training

with the assistance of the project team. The program may delivered in one of two ways: home visits and group training sessions. The school team should be responsible to help coordinate parent group training sessions in the school and concurrently run library/classroom activities for the children. Child and Family Services and the school should be prepared to distribute and present any materials developed.

Should a nursery school not currently exist in the community, the Director of Daycare/Nursery School should be pleased to provide assistance to parents establish one. As discussed earlier, the school principal can be instrumental in providing space and resources to assist in this process.

As a caution, although parental contact is essential, care must be taken not to overwhelm the parent with too many professionals dealing with them at one time. Each agency/member should have more or less contact with parent depending on the age of the child.

The Parent as a Team Member

The parents' role is critical in any child's life. In the at-risk situation many parents are caring but simply do not have the parenting skills required to provide appropriate, positive experiences for their children. Many parents resent being told what to do or how to raise their children. A high level of resentment exists toward organizations like Child and Family Service in families in high-risk situations. As discussed earlier, building an open and trusting relationship with the parent is the only way to involve the parent as a fully participating member of the collaborative team..

This process will take some time and considerable effort on the part of team members. A team member that has some existing relationship with the family should make initial contact with the parent(s), regarding the possibility of developing an

intervention plan. Again, care should be taken not to overwhelm the parents with too many professional people at once. The parents should be asked what their goals are for their children and what they think the team could do to help achieve these goals. (This process is critical. Parents have expressed surprise to author when asked for an opinion as they perceive of outside agencies to be dictatorial.) As parents become more comfortable with the concept, other team members can be slowly involved and introduced. Taking the time to really get to know the parents allows for building trust and pays dividends in greater sharing of meaningful information about the child and family.

After having identified the at-risk family, the collaborative team should meet to determine the following:

- what relationships currently exist between team members and the family;
- extended family that might be involved in any intervention;
- what strategies should be used to develop a trusting relationship with the parent, extended family and child.

The team should capitalize on any existing relationship with the family and work toward nurturing a positive relationship between the parent and the rest of the collaborative team. Once comfortable with the group and the goals of the project, the parents should be included in the planning process for designing and implementing the specific intervention for their child.

Developing an Inventory of Resource Materials.

Team members should meet to review existing materials currently being made available to parents on child development. The various agencies have a number of

excellent materials available in the form of brochures and pamphlets such as:

Early Start Brochure	Manitoba Children and Youth Secretariat
The First Years Last Forever	The Canadian Institute of Child Health
Get Set for Life	Health Canada and Partners
Reading With Your Baby – Catch-em in the Cradle	Unknown
Denver Developmental Activities	ages 9 months to 5 years of age

In addition government published brochures, there are many user-developed brochures, magazines, and newsletters. The team members should be prepared to share any materials they possess. Materials not suitable or unavailable may require the team to develop its own resource materials. Considering the specific skills that the group has identified, material resources may be limited. Lack of specific materials may be only one potential roadblock.

Identifying Potential Roadblocks and Solutions.

Under normal conditions, access to preschool children presents a problem for school personnel. Collaboration with other service providers, especially nursery school/daycare services, should provide a solution. In communities that presently do not have nursery/daycare facilities a nursery school should be set up within the school building itself. Initiation of this process may fall to the principal (project coordinator). The benefits would include (a) access for school personnel to the children ages three and four, prior to their entering the school system proper (clinicians, teachers and resource teachers), (b) children would have the opportunity to familiarize themselves with the school environment for shorter periods of time (3 to 6 hours per week), (c) baseline readiness skills in the behavioral, adaptive and academic domains would be more easily

measured, (d) the children would be exposed to a structured environment at an earlier age, (e) communication would be facilitated with regular newsletters and, (f) it allows for direct contact with parents dropping off and picking up their children.

Parental distrust of the system is a definite roadblock. Research shows that many parents are reluctant to participate in existing programs for various reasons. As discussed previously, some parents simply have a deep distrust of government agencies while others express resentment to being "told" how to parent. As discussed earlier, building a trust relationship with parents is crucial. As a possible solution for dealing with the resentment problem, the team should develop a coordinated and consistent approach to "selling" parents on the benefits that their children can enjoy beginning with the first home visit of nurse after the birth of a child and reinforced with each consecutive contact. For example, the school could provide the health nurse a letter of introduction and a complimentary book to be presented as a gift to each new parent. Parent contact could be maintained by including all new parents on a mailing list to receive school newsletters. Each partner agency could examine their possibilities for positive contact and capitalize on them. Another suggestion to increase participation in the project should be to invite all extended family members that are closely involved with the child to participate in both the planning and delivery stages of the project.

Other parents may not attend for logistic reasons. Two parental concerns leading to non-participation are a lack of daycare/baby sitting service for children not attending nursery, and having no means of transportation to and from any possible parenting sessions. In fact transporting students to nursery school presents a serious problem for some parents. The school could possibly address some of the child-care and

transportation concerns. Many schools promote programs in which senior students volunteer in classrooms with younger students under the supervision of a staff member. Utilizing such in school programs while coordinating library sessions or parenting courses can benefit both parent and child. Transportation is a larger problem. There should be no financial support for the initiative expected other than that provided by the individual school budgets. The collaborative team should explore possibilities including car-pooling and bussing of parents to sessions with their children on the regular school bus run.

Another concern is the potentially large amount of printed material that could be presented to parents. Many materials are presently available and distributed to parents are largely ignored. Any materials developed for parents should pass the "30 second test". Essentially materials, primarily pamphlets/brochures, should be developed so that they may be read and easily understood in 30 seconds. Anything more is likely to be ignored and discarded.

Funding, or rather lack of it, is always a potential roadblock. As previously stated, given present funding trends for the participating government agencies, additional funding for the project should not be expected. The only funding that may be available through the provincial government will be to parents to assist in costs associated with the nursery school/daycare programs. Private fundraising is a possibility, depending on the community. Presently many nursery schools do fundraising. Joint fundraisers with the school are a possible source of funds.

Although funding may prove to be problematic, the situation is not restricted to this project. One of the preconditions for successful collaborations cited by Morgan

(1995), is that individual collaborative team members be responsive (and perhaps creative) to individual funding arrangements. Each of the partners will be operating within the existing funding structures. A key to the project's success will be the team's ability to redesign and coordinate the use of the existing resources.

Available time and distance are definite roadblocks. Each of the team members has duties and responsibilities to fulfill in their regular job. This project will require frequent meetings for which time may be limited. Technology may provide solutions. The team should be prepared to use conference calls, faxes, e-mail, and possibly chatrooms to enhance intra-group communication.

A final potential roadblock lies in the recent federal legislation regarding the Freedom of Information and Personal Privacy Act (FIPPA) and the Personal Health Information Act (PHIA). These acts both specify the amount and nature of information that may be shared. Care should be taken that the collaborative team works within the confines of both pieces of legislation.

Evaluating the project will require the collection and recording of various data. The project coordinator should assume the responsibility for collecting and collating the results. In order to begin collecting data a control group must be identified and baseline data determined.

Setting Criteria for Baseline Data

The collaborative team should determine the qualitative life conditions and specific behaviors that will be observed and addressed by the intervention. As a starting point several factors should be considered:

i) socioeconomic status;

ii) parental education levels;

iii) family/extended family structure;

iv) prior involvement with a social agency;

v) presenting adaptive skills of the children;

vi) presenting social skills of the children;

vii) presenting academic skills of the children.

This list is again not comprehensive and would by necessity be developed by the entire team. In this suggested list of criteria, the first four provide at-risk data that will help identify children as at-risk. The last three criteria are the most important in that they are the observations that are relevant to the central issues of the project.

These criteria will form the basis of the qualitative data to be collected.

Establishing Baseline Data

Various readiness batteries and developmental tests should be explored to measure baseline data. Manitoba Health uses the Denver Developmental Activities series when working with families. These activity sheets present short, concise lists of specific activities that the parents can do with their children that are very well developed and are consistent with the skills that we are attempting to develop in children prior to school entry. The activities are designed to develop basic skills for children at various ages, birth to 12 months, 12 to 15 months, 18-24 months, 2 to 3 years, 3 to 4 years and 4 to 5 years. The four areas of skill development include speech and language, love (safety and a sense of belonging) , self-care and socialization, fine motor control and gross motor control. Although the Denver is not an assessment instrument, the types of activities will help the group identify how well the child is performing on similar tasks.

More formal measurement should be done using the Brigance Kindergarten Screen and at least two other Kindergarten readiness instruments. Many such readiness instruments are available on the Internet. Two examples of Kindergarten readiness checklists are from The San Ramon Valley Unified School District, available at www.lincoln.srvud.k12/ca.us/policies/kinder.html, and Polk County School District,

available at www.pcsb.k12.fl.us/prek/checlist. The committee should review several possibilities before the data collection document is finalized.

Subsequent groups of children entering Kindergarten should be assessed using the same instruments and the results compared with the initial group. This data should be used to determine the effectiveness of the interventions applied in the home and in the nursery school/daycare environments.

Similarly, establishing a second control group for children, aged 3 years, entering the nursery/daycare environment, and observing subsequent groups will provide data to determine the effectiveness of the interventions that were applied in the home.

Assessing Child Growth and Development.

McConnell (2000), cautions that there is a potential risk in assessment practices inappropriately applied and assessment information inappropriately used. As stated earlier in chapter 3 the team must take care to obtain or produce developmentally appropriate instruments. These instruments must be linked directly to the desired adaptive, social and academic skills that we are attempting to instill. McConnell also encourages assessment only as needed and that data collected be directly related to the child's progress, evaluating intervention effectiveness or the planning of new services.

The team will be using a general outcomes approach to assessment rather than a critical skills approach when designing the assessment instruments. The general outcome approach to assessment has a number of advantages (McConnell, 2000). Firstly, all general outcome measures within a particular domain are tied to common long-term goals. This is ideal for our project since we are focussing on the social, adaptive and academic domains. The goal of the intervention will be to raise the child's overall skill level within each domain rather than mastering any single skill. Secondly, general outcome measures can be designed to incorporate common measurement over an extended time frame. Doing so will provide an estimate of the rate of growth for individuals and groups. In addition to child/family evaluation, the project itself must be

closely monitored.

Identify the Processes for Monitoring and Evaluating the Initiative.

As discussed in chapter three, basic accountability should be examined on an ongoing basis, looking at efficacy, acceptability and practicality. Open communication with all service providers, parents and the children is required. In the initial stages, the collaborative team should be meeting frequently to establish the required definitions, criteria, and identify the control and experimental groups (possibly bi-weekly). Having, established the baseline data and with intervention being implemented, the collaborative team should meet monthly for the first year to check progress, discuss problems and to review and adapt individual interventions as required. Parents, by necessity of sheer numbers, should not attend all meetings. All parents with children in the nursery/daycare however, will meet with the specific team, working with their child twice during the particular year in progress, possibly in November and May. The parent should be provided with feedback from the team and should provide feedback in return.

This evaluation process should be ongoing and carried out both informally and formally. The collaborative team should meet formally twice a year. The group should meet in early September of each school to review the collected data for the group entering school and compare it to the collected data for the control group, and previous experimental groups. Should the team so decide, the similar data can be reviewed for home groups entering nursery daycare.

Informal evaluation of the project should also be ongoing. The degree to which it takes place will vary between different team members. For example, should the nursery school be delivered in the school building, contact between the nursery school teacher, the kindergarten teacher and the principal could be very frequent and allow for immediate feedback and problem solving. Maintaining informal contact between the principal-coordinator and the public health nurse will require a concerted effort. However, the contact should be maintained. It is suggested that the coordinator should be in contact

with each of the collaborative team members at least once or twice a month.

Summary

In this chapter the implementation process has been discussed. The implementation process should begin with development of the collaborative team. A primary consideration in the project should be involvement or establishment of the nursery school/daycare facility. The first task of the collaborative team will be to establish a common definition for "at-risk" and prepare to identify the target families. The basic skills to be taught must also be identified so that a common understanding of the desired behaviors is established. Each team member must understand their role in the delivery of intervention strategies. Parents must be involved. Inventories of available resources must be established and should materials not be available, the team should be prepared to develop them. The team should also be prepared to identify and find solutions for potential roadblocks to implementation. Finally the team should establish a control group, the initial experimental groups, develop or obtain the measurement instruments and establish the assessment and evaluation procedures for collecting data.

Chapter 5

Anticipated Results and Discussions

This chapter will examine the expected results and discussions.

Anticipated Results

The project should run for a minimum of five years. It is expected that the control group should exhibit the lack of basic life skills that will produce a two-year gap between them and their peers. Data will be collected through the use of several Kindergarten screens and at least adaptive/social skills inventory to establish a baseline. The control group will be monitored by regular school assessments for the remainder of the project.

Simply put, it is expected that the results of team intervention, which should be essentially teaching children specific skills, coupled with increased positive parental interaction with their children, will produce better behaved, better adapted and better academic students in the early years. These children will therefore be better prepared to learn. It is also expected that students will be able to maintain a higher academic success rate than the control group.

Discussions

The Denver Developmental Activities sheets, used by Manitoba Health display one very simple message for parents: Remember: Talk with your child - Play with your child - Enjoy your child!

This message is what we will attempt to reinforce by including parents as full participating members of the team and including the home environment as a "service delivery hub".

The purpose of this project is to ameliorate the effects of a disadvantaged home environment. These children live in poverty. This is not simply a lack of financial resources. They also lack positive parental attention, appropriate conversation, appropriately demonstrated affection, discipline, rudimentary manners and basic needs like food and shelter. What they do not have is positive life experience. These children

are truly disadvantaged.

The problems are severe and complex but addressable. Three basic beliefs of the author are that (a) the vast majority of parents of at-risk children truly care for them but simply do not know how to help them, (b) the people working in the social agencies are caring and committed professionals and (c) that working together we can make a huge difference in the life of a child.

The success or failure of this proposed model will rest on the team's ability to form a true collaboration with each other and the parents. Each member must be committed and dedicated to achieving the goal of the project: to prepare the child for learning in the formal school setting. This requires that the child have the basic adaptive and social skill necessary to enter the school environment and be ready to learn. They must know about rules, sharing, have some degree of independence and be considerate of others. To achieve this, the project must help the entire family, because only by helping the parent to interact positively with their children in the home will we be able to make any lasting change.

It would be naïve to believe that this project will change the world for all the children involved. However, as many teachers can tell you, a small positive action can sometimes produce major changes in a child's life.

This intervention program should provide the at-risk child with the basic adaptive and social skills that the majority of children learn in the normal course of living. It should, through parents and direct interaction with team members, provide some positive life experiences that might not otherwise occur.

Most importantly, the intervention should level the playing ground for the at-risk child as they enter the formal school system. Instead of having to learn basics that their peers learned three years earlier, they should be better prepared to succeed in school.

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